

**LOCAL  
GOVERNMENT  
ANNUITANT  
OR  
CONTINUANT  
ONLY**

**Instructions:**

To change plans or change to Family coverage, complete all sections of this form in ink. See page H-2 in the Dual-Choice book for more information. If you want to retain your current coverage, do not complete this form.

**PLEASE PRINT**

<b>GROUP: LOCAL GOVERNMENT ANNUITANT OR CONTINUANT</b>				<b>DUAL-CHOICE</b>		<b>HEALTH INSURANCE APPLICATION</b>	
Applicant – Last Name			First		Middle I.		Social Security Number
Address – Street & No.		City		State	ZIP Code	County	Home Telephone Number    Area/No.
Marital Status <input type="checkbox"/> Single	Married <input type="checkbox"/> Date _____	Divorced <input type="checkbox"/> Date _____		Separated <input type="checkbox"/> Date _____		Widowed <input type="checkbox"/> Date _____	
Spouse's/Ex-Spouse's Name & Social Security Number				OTHER HEALTH INSURANCE COVERAGE ( <i>You must complete this section</i> )			
<b>CURRENT GROUP HEALTH INSURANCE PLAN</b> Plan Name _____ Group No. _____  <b>NEW GROUP HEALTH INSURANCE PLAN SELECTED</b> Plan Name _____ <i>(list complete name, including location if part of name)</i>  <b>COVERAGE DESIRED</b> <input type="checkbox"/> Single <input type="checkbox"/> Family				Are you or a family member insured under Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes			
				If yes, list names of insured and Medicare effective dates.			
				Name: _____ Dates: Part A _____ Part B _____			
				Name (spouse): _____ Dates: Part A _____ Part B _____			
				Are you or a family member insured under another health insurance plan? <input type="checkbox"/> No <input type="checkbox"/> Yes			
If yes, list names of insured and plan.				Name: _____			
Name (Spouse): _____				Plan Name (Insurance Co.): _____			
Group No.: _____				Subscriber (Policy) No.: _____ Name of Employer: _____			

Last Name	First	Middle I.	Birthdate			Sex	Social Security Number	Appl. Rel. Code (see page H-2)	<b>YOU MUST INDICATE SELECTED PRIMARY PHYSICIAN, COUNTY in which located, and PROVIDER NUMBER (if available). Indicate <b>NONE</b> if electing the Standard Plan.</b>			CARRIER USE
			MO	DAY	YR	M/F						PRS Code
Applicant								N/A				
Spouse								N/A				
Eligible Dependent(s)												

**Return completed form to:**

EMPLOYEE TRUST FUNDS  
P.O. Box 7931  
Madison, WI 53707-7931

Upon receipt and acceptance by ETF, coverage will be **effective 01/01/2003**

I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and under the terms and conditions as described on the reverse side of this application. A copy of this application is to be considered as valid as the original. <b>Submit form with original signature.</b>										
<input type="checkbox"/> I am a retiree or surviving spouse/dependent <input type="checkbox"/> I am on continuation (eligible for a maximum of 36 months' coverage)				DATE SIGNED (MM/DD/CCYY)		<b>SIGN HERE</b> APPLICANT SIGNATURE				
<b>FOR DEPARTMENT OF EMPLOYEE TRUST FUNDS USE ONLY</b>										
ENROLLMENT TYPE <b>40</b>		EMPLOYEE TYPE		COVERAGE CODE		CARRIER SUFFIX		PARTICIPANT'S COUNTY		PROVIDER'S COUNTY
EIN <b>0000-001</b>			Group Number <b>77</b>			ETF Contact Person			Telephone (608)	
Monthly Premium <b>\$</b>				Date Received			COBRA Coverage Expires		Effective Date 01/01/2003	
FOR CARRIER USE		SN		FN		PL		ED		Premium Source    01    02    03    04

## TERMS AND CONDITIONS

1. To the best of my knowledge, all statements and answers in this application are complete and true. All information is furnished under penalty of Wis. Stat. § 943.395.
2. I agree to pay the current premium for this insurance.
3. I agree that any physician, hospital, or other institution who attends or has attended me, my spouse, or any of my children is authorized to furnish the insurance carrier with any and all information including the history obtained, findings and diagnosis. I authorize ETF to obtain all necessary information from the insurance carrier.
4. Any children listed on this application are unmarried and dependent on me, or the other parent, for support and maintenance. If over the age of 19, they are a full-time student; if over the age of 25, they are disabled of long standing duration and are incapable of self-support.
5. I understand that coverage will be cancelled and cannot be reinstated if premiums are not paid when due.